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O. C. WELBOURN, A. M., M. D., Editor
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SUMMARY OF REPORTS
FROM ONE THOUSAND PHYSICIANS

Remedies named as most useful in INFLUENZA		Remedies named as most useful in PNEUMONIA	
Aconite	788	Bryonia	723
Gelsemium	772	Aconite	617
Bryonia	707	Veratrum	576
Macrotys	384	Lobelia	468
Veratrum	353	Ipecac	411
Eupatorium	328	Asclepias	366
Lobelia	324	Gelsemium	293
Asclepias	268	Belladonna	169
Ipecac	236	Sanguinaria	134

Many physicians found it impossible to name **any** remedy as of "most importance," stating, very truly, that **each** is "most important" when its use is indicated. Others named two or more as most serviceable, giving usually the conditions under which each was used. **For example,** "Gelsemium is most frequently indicated, but where **sepsis** is marked, Echafolta or Echinacea becomes most important." A typical answer, often made, is as follows: "In nearly every case I find indications for **three** remedies—Gelsemium, Macrotys and Eupatorium." Again, "Aconite for fever, Eupatorium for bone-ache, and Macrotys for muscular soreness."

EXTERNAL APPLICATIONS

Libradol	618	Camphorated Oil	62
Compound Emetic Powder	185	Onion Poultice	38
Turpentine Applications	110	Iodine Applications	14
Antiphlogistine	96	Scattering	120
Mustard Applications	72		

Under "Scattering," are included many private prescriptions, as well as such applications as "mush jacket," "flaxseed poultice," "quinine and lard," and one each of the following: "capsicum, mustard and tar," "tobacco and wheat flour," "snuff and black pepper." "Dry cupping" finds one advocate.

It is often stated: "When I cannot get Libradol I use the best attainable substitute," hence many of the above may be considered as emergency applications.

Respectfully,

LLOYD BROTHERS.

Cincinnati, Ohio, March, 1919.

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The California Eclectic Medical Journal

Vol. ~~XLIX~~ III FEBRUARY, 1920 No. 2

:: Original Contributions ::

SURGERY OF THE KIDNEY

Dr. O. C. Welbourn, Los Angeles

Read Before the California State Eclectic Medical Society.

The subject which has been allotted to me by the chairman of the Surgical Section is a very large one and might readily occupy the entire time of this meeting. But I am sure such was not his intention and I have no thought of attempting to cover the subject as a whole or even one particular operation. Rather do I intend to suggest that operations upon the kidney are not the bugbear that we once thought they were. A couple of decades ago it was taught and generally believed that any operation upon the kidney was liable to be followed by a total suppression of urine. This much-feared complication, added to the usual dangers and complications of a major operation, caused the kidney to be avoided except as a last resort. My personal experience leads me to conclude that such an attitude was extreme and not justified by the facts. Not only do I believe that the dangers of the operation have been exaggerated, but I also believe that the end results are as satisfactory as those following work upon any other abdominal organ. A calculus causing suppuration in the kidney may be conpared to a calculus causing suppuration of the appendix. In each case the patient has a fatal illness. Both are strictly surgical and usually indicate a removal of the diseased organ, together with the offending concretion. Septicemia is equally marked and medicines equally useless prior to the necessary operative interference. Skillful post-operative care is required in each case and both patients are left permanently damaged. But should these operations be performed before suppuration has developed, the danger is small and the recovery perfect. The same compari-

son might be extended to chronic appendicitis and floating kidney. Neither is a serious operation, as major operations run, and in the end results are very satisfactory. I am aware that the suspension of the kidney has fallen somewhat into disrepute because of the tendency to a recurrence, but I believe this result is owing to a faulty technic. For several years I have used the lower fourth of the capsule as a hammock in which to suspend the kidney to the fascia, with the result that it "stays put" unless the patient meets with a severe fall. This operation also suspends the ascending colon—a very important matter. The operation as I now perform it is original.

Tumors, either malignant or benign, are occasionally met, but, even so, are no more hazardous than when found in other abdominal organs. Tuberculosis is always a formidable disease, wherever found, but when limited to one kidney it is curable by a Nephrectomy, and not infrequently a Nephrostomy will do the work. Before removing one kidney it is necessary to determine that there is a second, because a few patients have but one. May I also suggest that when an operation upon the kidney is indicated it should be done at once, just the same as any other operation. Procrastination increases the hazard—sometimes being the direct cause of a fatal termination.

GELSEMIUM

J. A. Munk, M.D., Los Angeles, Cal.

(Read before the California Eclectic Medical Society.)

My first favorite remedy after I began to practice medicine in 1870 was Gelsemium, and it has been my favorite medicine ever since. I have found it good for so many things that I regard it as indispensable to a successful practice. If for any reason I should ever be restricted to the use of a single medicine, Gelsemium would be my choice.

It is the remedy for sthenia and its use is, in a measure, indicated in all acute diseases. Given in any case of nervous excitement, or increased functional action of the vital organs, its beneficial effect is soon manifest. It may well be called the universal sedative, or febrifuge, as it is useful in the early stages of all fevers. It is also a valuable soporific, nervine, relaxant of nervous tension, and antispasmodic, and the physician who has ever used it once will use it again.

It not only acts promptly when the specific indications of "bright-eyes, flushed face, contracted pupils, increased heat of

the head and general headache" are present, but it is a suitable remedy in all fevers and inflammatory diseases when no other remedy is specially indicated. Under its kindly influence the vascular excitement is soon controlled and the burning fever subdued. The active brain and nerves are soothed and the patient falls into a quiet sleep.

Its physiological action is pronounced if given in large doses, first affecting the eyes by causing disturbed vision, which is immediately followed by drooping eyelids, the muscular relaxation extending rapidly to all parts of the body. By some the agent is regarded as a poison, but I do not consider it dangerous. I have used it freely for many years and have never seen or known any harmful results.

The dose of Colloidal Specific Gelsemium, which is the most perfect preparation of the drug on the market, ranges from one to thirty drops, repeated according to the effect produced. Except in case of an emergency, when a big dose is required and its full effect desired, the medicine is best prepared after the customary Eclectic fashion of mixing it with water, or other suitable vehicle, and given in small, frequently repeated doses for its gradual influence.

When the nervous system is overwrought and the patient is nervous, restless and wakeful, Gelsemium should be administered in full doses until nervous and muscular relaxation are produced. The full adult dose of the drug is thirty minims, or half a dram, but some large physiques require more. Even a teaspoonful is not too much in some cases; and in a desperate case the large dose should be given without hesitation. When the medicine has done its perfect work, the nerves become quiet and the muscles relaxed and flabby. A patient who won't stay in bed when he ought to be there is readily held hors de combat by filling him with Gelsemium.

It is a remedy to be thought of and used in any desperate case of convulsions, cerebro-spinal meningitis, eclampsia, mania and hydrophobia, or in any case where there is great cerebral excitement, or strong muscular contractions.

There is no other remedy equal to Gelsemium to control spasms in children, but it must be given in sufficient quantity to relax the muscles and put the little patient to sleep. It is surprising the amount of this medicine which is sometimes required in such cases to produce the desired effect.

A single dose of Gelsemium taken at night on going to bed will invariably break up a fresh cold; and if the patient is troubled with insomnia it will produce an all-night, sound, refreshing sleep. Taking the dose just before retiring avoids

experiencing any unpleasant effect, which, if it should develop, is not felt, as it passes off during sleep.

It is not depressing to the heart, and if more Gelsemium and les Asperine had been used in treating the "flu" there would have been fewer deaths from collapse.

BIOGRAPHY OF RICHARD ERNEST KUNZE, M.D.

J. A. Munk, M.D., Los Angeles, Cal.

Richard Ernest Kunze was of German-French parentage and was born in Altenburg, Saxony, April 7th, 1838. His father, John Jacob Kunze, was of an old Thuringian family and held the position for life of Court Horticulturist to Duke Joseph. His mother, Adelaide Collen, was the daughter of a French refugee.

Richard was the youngest of six sons and early showed an aptitude for scholarly pursuits. He went to school at the age of seven and received private instruction until he had completed his fifteenth year. Latin, Greek, French and English were included in his studies, but he never had the opportunity to take a university course. He took a lively interest in the natural sciences and received instruction from Schlenzig, the lepidopterist, Professor Apetz, the entomologist, and Karl Brehm, the ornithologist and African traveler.

Being unable longer to attend school, and bent on earning his own living, he engaged for a short time with his brother-in-law in the mercantile business; but this work did not suit him and he soon gave it up.

After his father's death in July, 1853, he decided to emigrate to America. On the third of September, 1854, he took passage for New York and shipped in the slow sailing bark Eliza from Bremerhaven, which journey occupied seven weeks. An inexperienced youth of sixteen, he fell an easy prey to thieves upon landing, who soon took all his money. He made his way into the country, where he found employment as a farm hand, which enabled him to learn the ways of the people and to speak the English language fluently. During this time he formed the purpose to study medicine, when he returned to the city and became a student of Dr. Charles J. Stearn, who also gave him instruction in medical botany and pharmacy.

He married Miss Ann McNamee, a native of Cardiff, Ireland, September 30th, 1857. There were no children born to this union.

In the same year he entered the Metropolitan Medical College and graduated in 1859; and again, from the New York Eclectic Medical College in 1868. About this time he became connected with the various Eclectic organizations of the city and state, and in 1871 he joined the National Association.

In 1875 he published his first monograph on Cactus, in which he gives a full description of the plants and calls attention to their value as a medicine in heart disease. This was followed in 1876 by a second publication, entitled "Cereus Grandiflorus and Cereus Bonplandii," that was accompanied by several fine colored drawings which were his own achievement. Two more papers followed in 1877, on "Cereus Triangularis" and "Phyllocactus Grandus," and three others, on "Cereus Macdinaldiae," "Cereus Serpentinus" and "Cereus Rostatus," in 1878. All of these papers were printed in the annual transactions of the New York Eclectic Medical Society. These various treatises comprise the most valuable literature extant on cactus. During these years he read many papers on medical, botanical and entimological subjects before various societies, which were printed in transactions.

The high esteem in which Dr. Kunze is held by the medical profession was evinced, recently, during the forty-ninth annual meeting of the California Eclectic Medical Society, when Dr. A. P. Baird read a paper on Cactus, in which he referred to the invaluable service that the Doctor rendered in developing its therapeutic virtues. He declared that this benefit to humanity was a more lasting memorial than any monument that could be carved from wood or stone.

Dr. Kunze wrote and spoke in several different languages and was a frequent contributor to scientific journals. He was an active member of the Torrey Botanical Club, an organization that met monthly in the Herbarium of the Columbia University; and likewise, was a charter member of the College of Archaeology and Esthetics, an institution also of the city of New York, incorporated in 1880. A pamphlet written by him on the "Germination and Vitality of Seeds" was published by the Torrey Society.

The death of his wife was a heavy blow and completely changed the current of his life. He forsook the haunts of men and wandered far afield to be alone and to commune with Nature. Being dissatisfied and his health failing, he sought relief, further, by making a complete change of environment. He left New York in December, 1895, and spent some time

in Colorado, but failing to find the benefit he craved, went to Arizona, where his health improved and the conditions were more to his liking.

He settled on a small ranch near Phoenix, where the weather was pleasant and he could spend his time comfortably out of doors growing fruit and cactus. He was extremely fond of the desert and spent much time in exploring its mysteries. Many new kinds of plants and insects interested him and he reveled in the abundance of his favorite plants of the cactus family which the desert produced. He discovered and described several new varieties of cacti, which were named by N. L. Britton and J. N. Rose, government botanists, as the Opuntia Kunzei, Echinocereus Kunzei, and Echinocactus Arizonicus.

He spent much of his time in gathering and growing rare specimens of cacti, which he shipped to foreign lands. Nearly all of the cactus plans found growing in European gardens during recent years were furnished by him, which occupation gave him a good living. When the world war broke out ocean traffic and the cactus trade ceased to exist, which affected his finances seriously and left him almost stranded. He contributed articles regularly to the Monatsschrift fur Kakteenkunde in Berlin describing the plants that he sent abroad.

Dr. Kunze was an unusually active, industrious and studious man and an original investigator of different problems. He could earn money, but never accumulated much, as he was always ready to spend it on anything which promised to promote his experiments. His life was a series of struggles with hardships that would have discouraged most men, but he was not disheartened and never complained. In physique he was tall, slim and angular, and his voice was strong and strident.

His writings have been collected in a group of Kunziana and filed in the Arizona Library of the Southwest Museum, Los Angeles, California. The last article from his pen on the Cactus Flora of Arizona was written in 1915 and published after his death, in the California Eclectic Medical Journal, in May, 1919. The complete manuscript of a book on Materia Medica, not yet printed, is also shelved there.

Dr. Kunze died in his eighty-first year, at his home near Phoenix, Arizona, on February 7th, 1919. He was nearly helpless for some time before his death and his mind seemed to be somewhat clouded, as he did not always recognize his friends when they called to see him. He lived very plainly and spent much of his time alone during recent years.

URETHRAL STRICTURE: PATHOLOGY AND TREATMENT

G. Allen Rowe, M.D., Buffalo, N. Y.

While I may not be able to tell you anything new or startling about urethral stricture, yet the subject is one of so vast importance that I think certain phases of it may at least justify a brief review. The text of this paper shall be confined more particularly to the pathology and treatment of stricture without considering its etiology or symptomatology. I do not deem it necessary to do more than merely mention spasmodic, irritable or large calibre strictures because in those forms the sub-epithelia lexudate has not yet become organized into connective tissue and consequently can be easily cured with comparatively simple remedial methods. It is the organic forms of stricture which inflict such fearful injury upon the human race and the cure of which crucially tests the knowledge and skill of our most experienced practicians. In order to successfully treat a true organic stricture of the urethra it is essential that a clear conception of the pathological conditions be kept in mind.

Pathology

Stricture is an unnatural reduction of the calibre of the urethral canal attended with changes of the mucous and muscular structures of its walls. These changes vary from an induration or thickening of the mucous membrane with proliferation of deep connective tissue to the formation of dense cicatricial tissue which involves the corpus spongiosum. Indeed, the corpus spongiosum is involved in practically all forms of organic stricture. The constriction itself may vary from a very small ,cord-like band, **linear** stricture, to a slightly broader one, **annular** stricture, or to a constriction two or three inches wide, **tortuous** stricture. In all kinds of strictures there is always thickening and desquamation of the epithelial layer, and the cylindrical epithelium is frequently transformed itno the stratified, pavement form. Indeed, almost all forms of transition may be noticed in the epithelial cells. The arteries of the spongy portion often show endarteritis or periarteritis, which may obliterate the vessels. The glandular and lacunar lesions are constantly causing fibrous nodules to form in the spongy portion. These nodules, of course, destroy the normal caliber and functions of the urethra and often result in periurethral abscesses, false routes or fistulous tracts which terminate in blind pouches. These tracts

are lined with pavement epithelium, and in closing them it is necessary to extirpate the whole tract or destroy them with the cautery. The opening of the urethra at the seat of stricture will be found in the roof of the canal rather than on the floor. The dilatability or consistence of stricture depends largely upon its age and amount of fibrous and elastic tissue.

Section of an annular or tortuous stricture shows a more or less imperfect ring of new inflammatory tissue, whose limits taper down gradually. This tissue is hard, yellowish-white near the lumen and darker peripherally, where reddish islets or seen, the result of hemorrhagic infarcts which form foci for new inflammatory tissue. Complete obstruction of the urethra is quite rare and perhaps never occurs except from some extensive trauma.

Treatment

We now come to what I deem the most important part of the subject of stricture, especially so far as the patient is concerned, and that is its treatment. The history of the treatment of organic stricture is replete with failures. Personally, I do not think too frequent failure to cure stricture is warranted, and from my viewpoint is indicative of carelessness, inexperience, faulty methods or possibly an imperfect knowledge of the condition on the part of the operator. Numerous methods of cure have been suggested and tested by surgeons of all nationalities with varying degrees of success. I shall briefly mention a few of those methods.

The use of steel sounds as a cure for organic stricture dates back many years, and while justifiable in some instances will probably not cure 5 per cent of cases. In the spasmodic variety or those of large calibre the judicious use of sounds will often afford marked relief and will even cure some cases; but in strictures of small caliber or those commonly classified as organic, I doubt whether a single cure was ever effected with sounds. I hardly think it would be entirely fair, however ,to place all failures to the credit of sounds themselves, because my observation is that a good many physicians and surgeons are very careless in using sounds and often use them improperly. It is no uncommon thing for patients to manifest a feeling of terror at the sight or suggestion of the use of a sound, owing doubtless to some former disagreeable experience. Such experience is seldom warranted because under ordinary circumstancs, and with reasonable skill, the introduction of a sound should be accomplished practically without pain and without shock. In an irritable urethra an injection of a teaspoonful of a 5 per cent solution of cocaine will

enable the operator to insert the sound without pain and without frightening the patient. I would remind my fellow physicians that the medical profession cannot justly claim a complete monopoly of public confidence, and it behooves physicians and surgeons to make good their claims and not admit of too frequent failure or frighten patients so they will seek relief from other sources.

My experience is that the best results are obtained, as a rule, from using the sound about once a week. Many surgeons advocate its use every day or every other day, but I think that entirely too often. I cannot conceive of a case in which a sound should be used every day.

Electrolysis—Some years ago electrolysis was heralded as the ideal cure for impermeable stricture, or those of small calibre, but the results have fallen far short of expectations. It must be admitted that the subject of electricity is not wholly understood, and that fact makes it a rather uncertain quantity to deal with so far as a curative agent is concerned. Then, again, its use must cover a period of from one to four months, which renders it impractical, especially for those living at a considerable distance from the operator. My own judgment as to the proper method of curing stricture is by the process of absorption, but thus far no thoroughly reliable method of absorption is known. Perhaps a more thorough knowledge of the therapeutic action of electricity will warrant a more general adoption of its use as a radical cure for stricture, but our present knowledge of its action certainly does not justify such a step.

Internal Urethrotomy—Of all methods employed for the radical cure of stricture at the present time that of internal urethrotomy affords by far the most satisfactory results. This is especially true so far as my own experience and practice go. In my earlier urethrotomy operations the results were by no means satisfactory, but I think the failures can be attributed principally to inexperience and lack of skill on my part. The ratio of cures in my first cases scarcely exceeded 60 per cent, but gradually it rose to 70 per cent and 80 per cent, and finally, in my last series of 100 cases, it reached the gratifying result of almost 92 per cent of cures. This is the best record I have ever been able to obtain, and while I have not been able to reach the 100 per cent mark, yet there has been a steady approach to it. Whatever success I have had I do not attribute so much to superior skill as to a faithful observation of technique as well perhaps as to a favorable series of cases.

Indications for Urethrotomy—Some operators do not advise internal urethrotomy on strictures of the membranous

portion of the urethra, claiming that external urethrotomy affords better results. My own experience does not support this claim. On the other hand, I advise or recommend internal urethrotomy in all cases of stricture, and at all parts of the urethral canal through which the urethrotome can be passed. Results from internal urethrotomy have proven incalculably better in my practice than any other method. Fibrous, resilient, irritable, large or small calibre strictures can all be relieved or cured by internal urethrotomy, but resilience and resistance to dilation are the strongest possible indications for a cutting operation. Strictures of the meatus and fossa navicularis do not respond satisfactorily to dilation and should always be cut. The incision should be made in the median line on the floor of the urethra and deep enough to overcome all resistance to the sound. Bleeding from this point may be checked by packing the fossa with iodoform or boracic acid gauze.

Technique—My usual method of procedure in an ordinary urethrotomy is about as follows: For a few days preceding the operation the patient, if possible, should be placed upon an antiseptic and mild diuretic treatment, of which the following is the best I have found: ℞ Specific gelsemium, 1 drachm; acetate of potash, 1 drachm; water 4 oz. Mix. Sig. Dose, teaspoonful four times a day. Five grain doses of salol four times a day will thoroughly asepticise the alimentary canal. The urethra and bladder are rendered antiseptic by irrigations of boracic acid 1 to 100, alternated with bichloride 1 to 5000. The urethrotome, sounds and all other instruments, except soft catheters, are immersed in a solution of carbolic acid 1 to 40 from one to two hours before the operation. As a local anesthetic I have found nothing better than a 3 per cent solution of cocaine retained ten or twenty minutes before operating. I have used this solution for about twenty years in a very large number of cases without a single unfavorable result. Sometimes there is slight cyanosis, sweating or faintness, due to the physiological action of the drug, and if it is rather marked I give a teaspoonful of whisky hypodermically or an ounce per oram. A laxative is given the evening before operation.

Operation—The success of an internal urethrotomy depends, of course, not alone upon an observation of technique, but also upon the manner in which it is performed. I cannot say that I am heartily in favor of that kind of operation we sometimes see mentioned in the newspapers, of which it is said, "the operation was successful but the patient died." I

am perfectly willing to allow the other fellow to enjoy the glory of all operations of that kind. In a series of something over 400 urethrotomies of different kinds I have not had the misfortune to lose a single case by death. This gratifying result I attribute quite as much to good luck and a favorable series of cases as to skill. Nevertheless, some experience and skill are essential in order to obtain a good result from urethrotomy. Scarcely any two urethrotomy operations are alike, and the operator must determine from his examination the character of the operation to perform. My favorite instrument is the Otis urethrotome, although other makes can be used quite as well. The instrument should be inserted gently and carefully with the concave surface looking towards the dorsum of the penis, as all strictures posterior to the navicular fossa are cut on the roof of the urethra rather than on the floor. There is always danger of making a false passage if the cut is upon the floor of the urethra and this should be guarded against. When the constricted point is reached the instrument is dilated as far as possible without exerting undue force and the cut made from behind forward. The cut should be deep enough to sever every constricted fibre, because one of the chief sources of failure is in superficial cutting. If there are several strictures, the one nearest the bladder should be cut first if possible, and all should be treated at one sitting. After each stricture is cut I carefully dilate a little further, so as to break down any fibres that may have escaped the blade of the knife.

Immediately after the operation, or as soon as the flow of blood lessens somewhat, I insert as large a steel sound as can be passed. The bleeding is not usually troublesome, although a stray blood vessel or one that has been forced out of its normal position may be severed. If the bleeding is too severe a sterilized bougie or sound may be inserted and retained in the urethra until the bleeding ceases. If necessary a T-bandage may be applied. Some surgeons insert an antiseptic catheter for twenty-four hours after an operation and follow by a flushing of 1 to 4000 bichloride solution. I do not especially favor this method owing to difficulty in keeping the catheter and urethra aseptic. I frequently draw the urine the first three or four times immediately after an operation with a sterilized catheter, which lessens pain and perhaps liability to rigors. At other times, I direct the patient to retain the urine from four to six hours if possible, and then allow it to pass without straining. Sometimes a clot of blood will clog the urethra, thus stopping the flow of urine,

and if so the urine may be drained with a catheter. This practically completes a simple or uncomplicated urethrotomy, and after it is completed I put the patient to bed for at least twenty-four hours and restrict his diet for several days, in order to favor rapid healing.

Double Incision—I wish to call attention to the fact that in some strictures of small calibre, or of a tortuous nature, a single incision is not sufficient to effect a cure. In those cases I am in the habit of making a double incision. These incisions are not made perpendicularly to the roof of the urethra, as in a single incision, but at an angle of about fifteen degrees on either side of the median line. With a double incision the degree of contraction will be much less and a normal calibre of the urethra is obtainable. As the life and development of a stricture depend upon its nourishment and blood supply, it is necessary to cut off the blood supply in order to obtain a cure. A single incision will not always destroy the blood supply in strictures of small calibre, whereas the double incision seldom fails. I have been making the double incision in strictures of this class for about five years with the most gratifying results. No large blood-vessels are likely to be severed by the double incision, but if they are, hemorrhage can be controlled as heretofore stated. In the double incision it is often necessary to cut from before backwards rather than from behind forwards. This can generally be done with the Otis urethrotome, especially if the backward incision is made second instead of first.

Medical Treatment—The treatment of stricture with medical remedies is not as satisfactory as we might wish it to be, so that too much must not be promised. Of course, internal remedies alone will not cure stricture, but in the earlier stages, or before deep cicatrization has resulted, cures may be effected with combined local and internal remedies of proper character. Much more dependence is to be placed upon local than constitutional treatment. The constitutional treatment should be administered with a view of keeping the kidneys and bladder in good condition as well as maintaining a neutral or unirritating state of the urine. Any remedy that will reduce inflammation and favor absorption of the cicatrix will have a tendency to cure stricture. Perhaps the agents best suited for this purpose are some of the salts of silver. Protargol in 1 per cent solution, or argyrol in from 1 to 20 per cent solution, injected night and mornig, will produce the most beneficial results.

By-Effects of Urethrotomy

Chills—One of the most annoying by-effects of urethrotomy is the traumatic chill, which may come on with the first urination or perhaps not for forty-eight or seventy-two hours after the operation. The chill is usually followed with a high fever which makes the patient very sick and uncomfortable for a day or two. I tried numerous remedies with a view of preventing these chills but with practically negative results until I began the use of gelsemium and acetate of potash, as named in the above prescription. While these remedies are not infallible, yet when used a few days before the operation the chills will be at least greatly modified and in most cases entirely prevented. Oil of gaultheria, in from two to five drop doses four or five times a day, is also an excellent remedy for preventing rigors.

Urethral fever is perhaps the most serious by-effect of all forms of urinary surgery, and is due to the absorption of bacteria or their poisonous products. Most physicians have noticed the sudden and pronounced fall of blood pressure which at times follows the most gentle insertion of the bougie or sound. Sometimes the effects are so pronounced as to result in collapse or syncope caused by reflex influence upon the circulation. When the kidneys are affected, instrumental treatment of the urethra should be very guarded, as the shock may be so great as not only to develop urethral fever but to induce anuria. This fact emphasizes the importance of thorough urethral antisepsis and careful urinary analysis before instrumentation and even catheterization is attempted. Albarran reports a case of internal urethrotomy in which the bacterium coli commune was found in the blood of the patient twelve hours after the operation. This shows how rapidly the poison may be absorbed, and, under favorable conditions, may prove fatal. The most effective treatment for preventing urethral fever is to be found in strict antiseptic measures. When urethral fever develops, however, antiseptic remedies, internally and locally, in the form of irrigation to the urethra and bladder, will check and control the progress of the fever in a few days. The liability of urethral fever following external urethrotomy is perhaps not so great as in internal urethrotomy, but even with this point in favor of external urethrotomy I never perform it except in absolutely impermeable strictures or emergency cases. The probability of irregular healing, annoying cicatrices or false passages is so great in the external operation taht it should be given secondary consideration whenever possible.

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PHYSICALLY PERFECT

From time to time there appears in the public press an article which expresses the author's original idea that not all men are physically perfect. These articles are remarkably alike in that each author seems to be surprised by his discovery. To the writer this seems passing strange, for perfection, physical or otherwise, in the absolute sense, obviously is unattainable. Hoping and striving for physical perfection may be a worthy effort, but the accomplishment can be but relative. The only human forms ever seen by us which approach perfection were composed of marble and probably represented idealized forms more than a living form. And at most they gave only the contour of the body. Color, movement, and texture were all absent; and that complicated inside machinery was entirely ignored. What they really do represent is undoubtedly beautiful and inspiring; but it is such a small part of the whole. Now, seeing that it is necessary to idealize in order to produce a human body perfect only as to contour, how is it possible to produce such a body perfect in all of its parts? The human body, like other animals, abounds in imperfections. Some of these are congenital, many are the result of disease. Whatever the cause it is the vocation of the

medical man to rectify them in so far as it is possible to do so. Without exception each individual can be elevated at least one step nearer physical perfection. All that is necessary is carry to the examination a clear image of the idealized human form and carefully and minutely compare with it the actual form of the person examined. Knowledge thus applied will reveal anatomical and physical imperfections otherwise hidden and suggest methods or remedies for their improvement.

THE TREATMENT OF WHITLOW BY THE STRICTLY NECESSARY INCISION

Paul Gallois, M.D.

It is not without some trepidation that I venture to discuss the treatment of whitlow in a journal of such wide circulation as the Monde Medical. Seeing that I do not specialize in surgery, it may savour of presumption on my part to deal with a problem outside my province. My presumption may appear the greater seeing that the principle of treatment which I seek to formulate is in opposition to generally received ideas. But I have been in practice some thirty-odd years and during this long period of time I have been called upon to treat a goodly number of whitlows. All my patients without exception have recovered without losing a phalanx and without ankylosis of the finger, accidents which I have witnessed often enough in the hands of others, even of surgeons of repute who might be expected to know how best to deal with such cases. I think, therefore, that I am justified in giving publicity to my procedure. I do so, be it remarked, only after a fairly long experience and with some hesitation. I fully understand that in so doing I incur a certain responsibility and I would not like to bear the burden of reproach of losses of fingers by those who followed my advice. I consequently beg my readers only to employ this method when they have convinced themselves of its advantages and are willing to assume entire responsibility for the results. I beg them, moreover, to revert to the classical procedures should they think that in a given case it would be exposing their patients to too grave risks to apply a method which they believe to be founded on error. In every operative procedure indeed, apart from the question of technique, there is always the "tour de main" which accounts for the fact that such and such a procedure, which proves successful in the hands of one practitioner, may fail in others. I

shall therefore explain what I am in the habit of doing, without venturing to give an opinion. I leave everyone free to imitate me or continue to apply the classical methods of treatment.

When I was a student the surgeons whose teaching I followed recommended their pupils to make free, deep incisions in all cases of whitlow. They chaffed us unmercifully when we made very small incisions, which they called medical incisions, and themselves took the scalpel in hand to enlarge our too timid openings. As to the depth to which we were advised to reach, it may be summed up in the formula, "down to the bone," which still echoes in my ears. Whether since the year 1880, where this souvenir takes me, surgeons' views in this matter have undergone a change I cannot say; in any event, a few months ago, at the Paris Society of Medicine, when I explained my own views on the subject, the surgeons present professed great anxiety as to the risks my patients might be running in consequence of my stricte necessaire incision, and announced their intention of persisting in the practice of making free, deep incisions.

It was on myself that, in 1884, for the first time I had recourse to the strictly necessary incision. I was at that time interne with Straus, and was making a goodly number of autopsies. I had a whitlow of the right middle finger and I was looking forward with considerable apprehension to the time when I should have to request a colleague to do the necessary. With the prospect of a free deep incision before my eyes, my courage failed me. I preferred to operate upon myself with my left hand, and you may believe me when I say that my incision was as small as it well could be. Well, I recovered without a hitch, and nowadays you would really have to look very close to discover even where it was.

Since then I have sought to apply in my practice the rather pusillanimous procedure which I applied to myself and which had succeeded in my own case. What I aim at is to make as small an incision as possible but big enough, all the same, not to allow of accumulation of pus. This is what I call the strictly necessary incision. Each day on applying the dressing I make sure by pressure round about the wound that no matter is accumulating in the depths. As a matter of fact, it is highly important that the doctor should daily ascertain by inspection that his incision is sufficient. He must bear in mind that he runs certain risks and that he must be prepared to extend the original incision should it prove inadequate. It would be allowing the patient to run certain avoidable risks only to see him every three or four days and a "fortiori" only once a week.

Very rarely does it happen that an incision one centimetre in length does not prove sufficient; indeed, I generally make even smaller incisions than this. In case of shirt-button abscesses it is recommended not to be satisfied with opening up the superficial ampulla, but to open up the subcutaneous focus as well. In principle I adopt this recommendation, but in practice if, after having removed with scissors all the detached epidermis, I find that the deep abscess can empty itself sufficiently through the orifice of communication, then I do not enlarge the orifice. If evacuation appears to me to be inadequate I merely pass the blade of a narrow scalpel through the orifice and this, as a rule, answers the purpose.

As to depth, I only try to cut through the ceiling of the abscess and not to incise the floor. I carefully avoid going down to the bone, as used to be recommended by old-time authorities. I am inclined to think that it was by making too deep incisions that the pus found admission to planes into which it would not otherwise have penetrated. We must be afraid, in my opinion, of opening up the sheaths and the periosteum, thus infecting the tendinous synovials and the bone.

From this point of view our views have undergone a radical change in reference to the evolution of an abscess. Formerly it was thought to start in the depths of the tissues with a tendency to open outside, consequently the object was to reach the abscess right away, however far away it might be. At the present time, thanks to microbial theories, we know that, apart from osteomyelitis and tuberculosis of bone, the origin of an abscess is always superficial. Micro-organisms have entered through some slight, triflling solution of continuity in the epidermis. If they are unable to get out they set up suppuration, and if there be retention the pus tends to burrow more deeply. We have only to bring retention to an end for recovery to take place, so to speak, naturally. The opening need not be big to put an end to retention. Too free and too deep incisions passing beyond the limits of the abscess only convey infection to regions previously free therefrom.

In short, owing to interventions as discrete as possible I cure my patients in the course of a few days, not only without stiffness and mutilation but in most instances without even a visible cicatrix. Then too, a fact which is not without its importance, I do not cause my patients any unnecessary pain. I remember that formerly, when my chiefs had to open an abscess it took four of us to hold the patient down and he uttered yell upon yell when being operated. Personally I always operate without any assistance, without anaesthesia,

knowing perfectly well that my patient will not upset people in the next room by his cries. Often indeed I give no pain at all, as for instance when I merely open the superficial blister and remove the detached epithelium. If I have to dig my lancet into the subcutaneous focus I warn him that it will hurt a bit but as my incision is very rapid and of limited extent the pain is quite bearable.

For this method of the strictly necessary incision to succeed it must obviously be applied early enough, we must not wait till the pus has inflicted intensive damage. But the reason why so many patients postpone applying for treatment is that they fear the operation which has the reputation of being horribly painful. If they know that they can be relieved forthwith, almost without pain, they will assuredly display less hesitation in consulting a doctor.

I may be told that my timorous method is acceptable for mild cases but would be dangerous in grave cases. That may be so but I only speak of what I have seen and do not think that chance sent me solely patients unworthy of a more energetic treatment. Had I written this article after, say two or three years' experience, I might imagine that I had been favored with a fortunate series. But after 35 years' experience I think I may eliminate this hypothesis. At any rate I cannot be accused of having made too hasty a communication or one insufficiently mature.

This article was finished and I was on the point of dispatching it to the printer when something happened that induced me to defer the dispatch. I was called upon to incise an enormous anthrax of the neck and while dressing this patient I said to myself that I stood a good chance of getting infected and developing a whitlow. Such a whitlow might be serious and it would really be too foolish for me to have to submit to a big incision just when I was urging a minute incision. My apprehensions were justified in part for I had a whitlow on the same right index finger as 35 years before but on the ulnar side of the nail while the previous one was on the radial side. I never had any other whitlows and it was curious that I should have had one just when writing on the subject. I will give the notes of my case which will enable me to describe my exact procedure for it is possible that my method of dressing may have something to do with the results.

It was on June 24 that I began to feel pain in the finger. I immediately applied a moist dressing, that is to say, I took some cotton wool dipped in a solution of corrosive sublimate

and applied it, without squeezing out, to the tip of the finger. I covered it with a sheet of piece of gutta percha tissue and fixed it with a bandage. I renewed the dressing at midday and at night when I felt that the dressing was getting dry. By maintaining a compress steeped in a solution of corrosive sublimate I have often been able to absorb a threatening whitlow. This time, however, no abortion took place. On the 28th at 6 p. m., on reapplying the dressing I noticed a small white spot at the edge of the nail, two or three millimetres across. I opened this with the point of a lancet and as is my practice I sought to remove with fine blunt pointed scissors the whole of the detached epidermis. But there was so little, the incision was so short and I was so clumsy with my left hand that I was not successful. I let matters slide thinking that after all on the next or the following days the epidermis would become detached and would give a better grip, but this was not the case. Suspecting a shirt-button abscess I squeezed the finger and this gave exit to a comparatively large quantity of thick pus. I reapplied the same dressing. On the morrow, squeezing it morning and evening, I got out more pus, first serous and then scarcely mattery at all. On the 28th nothing came out. That day there was a meeting of the Society of Medicine of Paris and I promised myself that I would show my finger to my colleagues but circumstances prevented my doing so. A little later there was some infection of the bed of the nail. I treated this by applying balsam of Peru with a match then a little cotton wool dipped in the perchloride solution, wrung out and dipped in glycerine. Glycerine in these cases strikes me as being an excellent dressing. It runs freely into the out of the way corners in a way that water does not do. Then too, it dehydrates the tissues thus arresting superficial suppuration. Balsam of Peru seems to act in much the same way. At the end of the month I was well again and it is today, July 5, that I am writing this article. In short, my whitlow was cured in a week without my having to cease work and except for a little desquamation of the inflamed part and barely visible swelling no trace remains. I can therefore only congratulate myself on not having incised more freely and more deeply, and on having adhered to my plan of a strictly necessary incision.—Le Monde Medical.

ACUTE ANTERIOR POLIOMYELITIS—THE ETIOLOGY AND BEST TREATMENT TO PREVENT DEFORMITY

Henry J. Schireson, M.D., Newark, N. J.

The etiology of acute anterior poliomyelitis has been given much attention recently, and the consensus of opinion confirms the theory that it is a lesion of the motor cells of the anterior horns of the spinal cord through the arterial blood supply of the anterior and two posterior spinal arteries.

Bacteriological examinations made by such men as Schultz, Dercum and many other scientists confirm the opinion of the disease being epidemic, infectious, contagious and traumatic, and that toxines of the alimentary canal are one of the most sourceful means of infection, which is proved by the fact that more cases of infantile paralysis occur in the month of September than any other four months of the year during the disease or after the child begins to convalesce from an attack of summer complaint.

That the disease is at times epidemic is unquestioned and established by ample evidence, and that a common source of infection from the milk supply is not lacking in evidence and deserves consideration. The conclusion of Scheele, Holt and Hartlett is that the disease is contagious, and forty instances are reported where the disease has appeared in from two to seven members of the same family. Lovett and Lucus report 635 cases of infantile paralysis in Boston in 1907, and the greater number of these occurred in the second year of life, and while the etiological evidence substantiated the infectious theory, the direct bacteriological proof did not sustain that theory conclusively; but the character of the onset, the epidemic distribution, the apparent contagiousness and experimental production of paralysis in animals all point in this direction. The fact that the disease selects children during dentition and the summer months, and especially August and September, offers evidence of gastro-intestinal disease, and suggests a possible source of infection in the intestinal tract from a milk bacillus, which liberates a toxin, the harmful agent, and then disappears. The etiological conclusion of the literature on the subject does not warrant the statement that any one cause produces the disease, but many, because various degrees and kinds of illness often precede the attack, such as malaise, headache, loss of appetite, varicella, measles, scarlet fever, cholera infantum, otorrhea, and many other diseases incident to child life. Hence, the disease may be the clinical expression of the reaction of the spinal cord to one of several causes, of which infection may well be considered one.

At present we must observe, study and collect material, remembering that we may be dealing (1) with a specific infectious disease; (2) with an infection due to one of several organisms; or (3) with a disease of more than one origin, not always necessarily infectious. The physician perceives plainly that his patient is suffering from an acute infectious process of some kind, but he is surely to be pardoned if he fails to appreciate its true nature, for until paralysis makes its appearance no pathognomonic symptoms are seen.

I have myself seen a few cases called cerebro-spinal meningitis, which proved to be monoplegia or paralysis, when the severe symptoms had disappeared; hence a thorough knowledge of the nervous system is absolutely necessary, otherwise we will be treating poliomyelitis for scorbutus, torticollis for cervical adenitis, trismus for inflamed wisdom tooth, and knee-jerk for morbus coxarius, all producing deformities from abnormal changes in the nervous system.

The treatment of infantile paralysis has received its share of special attention from the best orthopedic surgeons in this country and Europe, and yet a majority of the cripples seen on our streets are caused by anterior poliomyelitis, so that it has been truthfully said that "nothing is more misleading than facts, unless it is figures." Such a statement is not ill timed when we consider the inefficiency of our former treatment and the number of cripples seen daily. The plan of treatment I have recently used in acute infantile paralysis cases has been with the influence of environment and lapse of time. As soon as the disease is recognized I put the patient in a recumbent position until spontaneous recession takes place, which will often take several months and sometimes more than a year, and right here is where the difficulty arises in keeping a child well and quiet, and yet it can be done to a certain extent, and we have the consolation of knowing we have selected the lesser of the two problems under consideration. The deformities seen are more frequent in the lower extremities than in the upper, which is not strange when we pause to think that the arms are free, while the legs bear the weight of the body, so when the joints of the lower extremities are affected, or even suspected, they should be protected by recumbency or proper mechanical appliances or braces; hence the rational conclusion is physical simplicity in cause and effect.

Disability from this disease is seen almost ten times as often in the lower as in the upper extremities, and yet in the early stage the paralysis is found in all parts of the motor system, and in the recumbent position we find it absolutely favorable to spontaneous recession of the paralysis. The arms and hands retain this advantage when the patient is erect, but

the impaired muscles of the legs and feet give way at once when they meet the weight of the body, and become attenuated and elongated, and could not be put in a position more damaging to them, and the result is plainly seen in all kinds of clubfoot, short tendo Achilles, anterior muscles of the thigh and frail joints. Therefore, if in acute anterior poliomyelitis, we can by means of a recumbent position give to all the muscles alike the same opportunity for spontaneous recession of the disease in them, we will not see ten times as many deformities in the lower extremities as we do in the upper, and the number of deformities from this disease will be materially reduced.

Another treatment in this disease, when it has taken on the chronic form and the deformity is well marked, which has proved very satisfactory in my practice, is repeated plaster casts at short intervals, while the patient is under an anesthetic and muscles and tendons easily stretched; the deformity can gradually, with this treatment, be overcome, and the limbs made stronger and more useful than they would be in overcoming the deformity by myotomy or tenotomy, although there are some cases that require both methods. However, these methods should not supplant their valuable adjuncts of passive motion, exercise, electricity, massage, local applications and judicious medication, all of which will make it easier to carry out the recumbent position with better ultimate results.—(National Quarterly.)

NEWS ITEMS

Born: To Dr. and Mrs. Kenneth Baber, Los Angeles, a daughter, on December 19, 1919.

Died: A. A. Guglieri, M.D., Madrona, California; graduate of the California Eclectic Medical College, 1901, on November 30, 1919, aged 60 years.

Dr. Jacob S. Rinehart has moved from Lexington, Mo., to No. 200½ West Commercial Street, Springfield, Mo., having bought the practice of Dr. C. A. Tucker.

Dr. L. S. Asbury of Rising Sun, Nebr., has bought the practice of Dr. J. S. Rinehart and moved to Lexington, Mo.

Dr. J. E. Shearer has moved from Cloverdale, Oregon, to Tillamook, Oregon, where he is associated with Dr. A. C. Crank.

Dr. Walter H. Fearn, Lakeport, California, has been reappointed County Physician for another term. The new Lake County Hospital, a reinforced concrete structure on a thirteen-acre plot, will be opened in the very near future. The hospital will admit private patients as well as charity and as the building and equipment are modern in every respect, Dr. Fearn will be able to do his work to the best advantage.

CLUB RATES

The various Eclectic publishers have decided to renew their special club offers to December 1, 1918, on a straight 10 per cent reduction, where two or more journals are ordered at one time. If you are not familiar with any of these journals, samples may be obtained on request.

	Price.	Club Rate.
California Eclectic Medical Journal, 819 Security Bldg., Los Angeles	1.00	.90
Eclectic Medical Journal, 630 W. 6th St., Cincinnati, Ohio	2.00	1.80
Ellingwood's Therapeutist, 32 N. State St., Chicago, Ill.	1.50	1.35
National E. M. A. Quarterly, 630 W. 6th St., Cincinnati, Ohio	1.00	.90

You may subscribe to any or all of the above journals through this office, the only condition being that subscriptions are paid in advance and 10 per cent discount allowed on an order for two or more, including this Journal.

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